The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to kingcounty.gov/benefits. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 206-684-1556 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 person / $900 family (Gold) $600 person / $1,800 family (Silver) $800 person / $2,400 family (Bronze) Doesn't apply to prescription drugs, preventive care or hearing aids.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't met the deductible, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $1,100 person / $2,500 family (Gold) $1,600 person / $3,800 family (Silver) $2,000 person / $4,800 family (Bronze) For out-of-network providers $1,900 person / $4,100 family (Gold) $2,400 person / $5,400 family (Silver) $2,800 person / $6,400 family (Bronze)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. **Note:** Amounts you pay for deductibles, copayments, and coinsurance go toward your out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, prescription drugs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit. Separate out-of-pocket limit for prescription drugs: $1,500 person / $3,000 family.
Will you pay less if you use a network provider?	Yes. See www.regence.com or call 1-800-376-7926 for a list of network providers.	This plan uses a provider network. You pay less if you use a provider in the network. You will pay more if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose for covered services without a plan referral.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	Coverage limited to 60 visits/year for acupuncture. Coverage limited to 33 visits/year for spinal manipulations.
	Specialist visit			
	Preventive care/screening/ immunization	No charge	35% (Gold) 45% (Silver) 45% (Bronze)	Deductible is waived
If you have a test	Diagnostic test (x-ray, blood work)	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	None
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at kingcounty.gov/benefits	Generic drugs	$7 copay/ retail prescription $14 copay/ mail order prescription	$7 copay plus remaining balance after pharmacy is paid at network rate	Covers up to a 30-90 day supply, depending on the drug, for retail and mail order prescriptions through CVS Caremark.
	Preferred brand drugs	$30 copay/ retail prescription $60 copay/ mail order prescription	$30 copay plus remaining balance after pharmacy is paid at network rate	
	Non-preferred brand drugs	$60 copay/ retail prescription $120 copay/ mail order prescription	$60 copay plus remaining balance after pharmacy is paid at network rate	
	Specialty drugs	According to the generic, preferred and non-preferred drug categories	Only available through CVS Specialty after one courtesy fill at retail pharmacy	Coverage limited to a 30-day supply (mail-order prescription through CVS Specialty only).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	Preauthorization may be required. Diagnostic services not covered unless medically necessary.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Emergency or non-emergency care, after $200 copay/visit: 15% (Gold) 25% (Silver) 25% (Bronze)	Emergency care, after $200 copay/visit: 15% (Gold) 25% (Silver) 25% (Bronze) Non-emergency care, after	Copayment waived if directly admitted as an inpatient to a hospital or facility.

* For more information about limitations and exceptions, see the plan or policy document at www. kingcounty.gov/benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			$200 copay/visit: 35% (Gold) 45% (Silver) 45% (Bronze)	
	Emergency medical transportation	15% (Gold) 25% (Silver) 25% (Bronze)	15% (Gold) 25% (Silver) 25% (Bronze)	None
	Urgent care	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	Preauthorization may be required. Diagnostic services not covered unless medically necessary.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	Preauthorization required for inpatient services.
	Inpatient services			
If you are pregnant	Office visits	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g, ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Preauthorization required. Coverage limited to 130 visits/year for combined network and out-of-network services. Deductible applies.
	Rehabilitation services	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	Coverage limited to 60 inpatient days/year and 60 outpatient visits for all therapies combined: massage, physical, occupational, and speech.
	Habilitation services	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	Coverage is limited to neurodevelopmental therapy.
	Skilled nursing care	15% (Gold) 25% (Silver) 25% (Bronze)	35% (Gold) 45% (Silver) 45% (Bronze)	Preauthorization required.
	Durable medical equipment	15% (Gold) 25% (Silver)	35% (Gold) 45% (Silver)	Coverage for hearing aids limited to $500 in three calendar years.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		25% (Bronze)	45% (Bronze)	
	Hospice services	No charge	No charge	Deductible applies.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses			
	Children's dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing Aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: The following agency can help if you want to continue your coverage after it ends: Department of Health and Human Services, Center for Consumer Information & Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms. Other coverage options may also be available, including buying individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Regence BlueShield at 800-376-7926 or www.regence.com, or CVS Caremark at 844-380-8838 or www.caremark.com/wps/portal.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Having a Baby
(Nine months of in-network prenatal care and a hospital delivery.)

■ **The plan's overall deductible** (Bronze)	**$800**
■ **Specialist coinsurance** (Bronze)	**25%**
■ **Hospital (facility) coinsurance** (Bronze)	**25%**
■ **Other coinsurance** (Bronze)	**25%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, the patient would pay:

Cost Sharing	
Deductibles	$800
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
Total the patient would pay	**$2,060**

Managing Type 2 Diabetes
(One year of routine in-network care for a well-controlled condition.)

■ **The plan's overall deductible**	**$800**
■ **Specialist coinsurance** (Bronze)	**25%**
■ **Hospital (facility) coinsurance** (Bronze)	**25%**
■ **Other coinsurance** (Bronze)	**25%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, the patient would pay:

Cost Sharing	
Deductibles	$800
Copayments	$525
Coinsurance	$675
What isn't covered	
Limits or exclusions	$55
Total the patient would pay	**$2,055**

Simple Fracture
(One in-network emergency room visit and follow up care.)

■ **The plan's overall deductible** (Bronze)	**$800**
■ **Specialist coinsurance** (Bronze)	**25%**
■ **Hospital (facility) coinsurance** (Bronze)	**25%**
■ **Other coinsurance** (Bronze)	**25%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

$ Total Example Cost	**$1,925**

In this example, the patient would pay:

Cost Sharing	
Deductibles	$800
Copayments	$0
Coinsurance	$481
What isn't covered	
Limits or exclusions	$0
Total the patient would pay	**$1,281**

Note: These numbers assume the patient has **not** participated in the Healthy Incentives wellness program and has the **Bronze** out-of-pocket medical expense level. For more information about Healthy Incentives, please go to kingcounty.gov/healthy-incentives.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.